NOTICE AND ELECTION FORM

FEDERAL EMPLOYEES' GROUP LIFE INSURANCE (FEGLI) PROGRAM
ELECTION FORM: EXTENSION OF COVERAGE WHEN CALLED TO ACTIVE DUTY

Name of Employee: _____ Date: _____
You must make your election on this notice and return it to the employing office before the end of your 12 months in nonpay status or your FEGLI coverage will automatically terminate at that time.

Public Law 110-181, the Department of Homeland Security Appropriations Act, enacted January 28, 2008, authorizes the continuation of FEGLI coverage for an additional 12 months, up to a total of 24 months, for Federal employees called to active duty in the uniformed services.

We have determined that you are eligible to continue your FEGLI coverage. Currently, if you are in a nonpay status on the agency rolls while on active duty, the FEGLI coverage continues free for 12 months. If you separate to go on military duty, for FEGLI purposes, you are also considered to be in nonpay status. FEGLI continues free for 12 months or until 90 days after military service ends, whichever date comes first. At that time, the coverage terminates, subject to a 31-day extension of coverage and the right to convert to an individual policy.

The new law allows you to continue FEGLI coverage and or reduce the coverage of any optional insurance for an ***additional*** 12 months. Then, it will end with a right to convert to an individual policy. During the additional 12 months of coverage, you must pay both the employee and agency share of premiums for Basic coverage and the full premium for any Optional coverage (there is no agency contribution). The new law allows coverage to continue only for the additional 12 months.

You have two choices: (1) Elect to have your FEGLI coverage terminate at the end of the first 12 months of nonpay status ***or*** (2) elect to continue the coverage for an additional 12 months and agree to pay the premiums for this additional time period.

If you wish to continue your FEGLI coverage for an ***additional*** 12 months, you must agree to the following terms and conditions. Please indicate your election on this notice by writing your initials next to your election, and print your name and sign your full signature where requested.

TERMINATION: If you indicate in the notice that you elect to terminate your FEGLI coverage at the end of the first 12 months in nonpay status or if we do not receive a completed election form from you prior to the end of the first 12-month period, your FEGLI coverage will be terminated at the end of 12 months in nonpay status. Your coverage will continue for an additional 31 days at no cost to you. During those 31 days, you will be eligible to convert to an individual policy and you will be given information regarding your right to convert to an individual policy.

CONTINUATION: If you elect to continue your FEGLI coverage, you must pay the premiums, both the employee and agency share, for Basic coverage and the full premium for any Optional coverage. You must submit payments directly to the designated Payroll Disbursing Office on a bi-weekly pay period as instructed by your employing agency. Employees will be permitted to send in advance payments due to the sensitivity of their mission and possible delay of mail service at various locations.

Notice and Election Form

I have read this notice, and I understand my choices.

_____ I elect to terminate my FEGLI coverage at the end of 12 months in nonpay status, subject to a 31-day extension of coverage and the right to convert to an individual policy. I understand that the coverage will be reinstated automatically upon my return to work in pay and duty status in a FEGLI-eligible position.

_____ I elect to continue my FEGLI coverage for an additional 12 months after completion of my first 12 months in nonpay status. By choosing to continue coverage I agree to pay the applicable premiums, both the employee and the agency share for Basic coverage and the full premium for any Optional coverage, for each additional month after the first 12 months in nonpay status. My failure to pay the premiums on a bi-weekly basis within the required timeframe (FEGLI coverage will terminate after two consecutively missed payments) will constitute a voluntary cancellation of my coverage, subject to the 31-day extension of coverage and the right to convert to an individual policy.

_____ I elect to continue and reduce my FEGLI coverage for an additional 12 months after completion of my first 12 months in nonpay status. By choosing to reduce my FEGLI coverage I agree to pay the applicable premiums, both the employee and the agency share for Basic coverage and the full premium for any Optional coverage, for each additional month after the first 12 months in nonpay status. My failure to pay the premiums on a bi-weekly basis within the required timeframe (FEGLI coverage will terminate after two consecutively missed payments) will constitute a voluntary cancellation of my coverage, subject to the 31-day extension of coverage and the right to convert to an individual policy. ***A letter must accompany this form outlining the FEGLI coverage that you would like to become effective after your initial 12 months.***

Upon return of the completed form, your Human Resources Office will provide you with additional information to include the bi-weekly cost of premiums, effective date, timelines, copy of the payroll remittance form, and explanation on what happens when premiums not received. The cost of your premiums are subject to change due to the coverage that you elect, increase in pay, and changes to age groups which are used to calculate the cost of FEGLI coverage. Upon your return to duty, your FEGLI coverage will be restored to the election which was in place prior to being placed in a nonpay status. Your servicing Human Resource Office Representative must fax this form to the Defense Civilian Payroll, Fax# (317) 510-9771 or DSN 699-9771.

_____ _____
(Employee's Name – Please Print) Employee's Social Security Number

_____ _____
(Employee's Signature) (Date)

_____ _____
(Employing Agency Representative Name) Employee's Payroll Office Identification (PRO)
(i.e. The PRO ID is an eight digit number such as 97380200, 97380300, 97390600 etc. shown on the LES.)

_____ _____
(Employing Agency Representative Signature) (Date)

If you have any questions, contact _____ via email _____ or phone, _____.

[Insert name, email address, and phone number of agency contact]